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A Nursing Case Report on Managing End of Life Feeding Challenges in a Farmer with Terminal Esophageal Cancer and Severe Dysphagia

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Case Report

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Abstract

Background

Esophageal cancer is common in the highlands of southern Ethiopia. Hot porridge and steaming coffee are daily staples. Nurses in this region care for patients who cannot swallow their own saliva. They reassure fathers who fear they will not see their children grow. They also face a healthcare system that moves too slowly for cancer. This case report follows the CARE Guidelines. It tells the story of one patient and the nursing care that kept him alive while he waited for surgery.

Case Presentation:

A 45-year-old male farmer from a rural community in an endemic region of Ethiopia came to our university hospital. He had T1 distal esophageal cancer. Over six months, progressive dysphagia made eating impossible. First, he could not swallow solids. Then he could not swallow liquids. Finally, he could not swallow his own saliva without severe pain. His body mass index was 16.37 kg/m². He was depressed and hopeless. He had watched a neighbor die from the same disease. His history showed risk factors common in his community. He had smoked for seven years. He had chewed khat weekly for ten years. He had consumed scalding-hot foods and drinks throughout his life.

Nursing Interventions:

The nursing care was not a checklist. It began with sitting beside him and listening to his fears. We gave intravenous fluids every eight hours. We rotated Normal Saline, DNS, and Ringer's Lactate. We added Vitamin B-Complex and dextrose. His esophagus was blocked. He could not eat. The fluids kept his body nourished. We managed his pain with tramadol. We also believed him when he said he hurt. We taught him about his early-stage cancer. This gave him hope. He had thought he would die. Now he understood his cancer was treatable. But we lacked a psychologist for his despair. Staff had no time for long conversations. The surgical schedule was limited to two days per week. Cancer does not wait for schedules.

Outcomes:

After three days of intensive nursing care, his epigastric pain decreased. His fluid balance stabilized. His vital signs stayed steady. His mucous membranes were moist again. Most importantly, his fear began to ease. He understood that T1 cancer is early and operable. It is not a death sentence. But the waiting continued. His spirit and body weakened slowly. Delayed surgery, no psychological support, and overburdened staff remained problems. Good nursing cannot fix a broken system.

Conclusion

Nursing care for esophageal cancer patients in resource-limited settings has real impact. It also has real limits. When a patient cannot eat, the nurse feeds them through IV lines. When a patient loses hope, the nurse offers facts that help them hope again. But nurses cannot operate. They cannot create psychologists who do not exist. They cannot make a two-day surgical schedule serve a ward full of cancer patients. Holistic nursing care is not a luxury. It is necessary. Healthcare systems must support the nurses who stand at the frontline of cancer care.

Introduction

In the surgery ward of our university hospital in Ethiopia's Central Region, we see esophageal cancer often. The diagnosis never becomes routine.

The patient in bed seven was a father and a farmer. He woke before dawn to work his land. He was one of many. But to his two wives, his five children, and his brother-in-law at his bedside, he was irreplaceable. To me, his nurse, he showed why this work matters. He also showed why it breaks your heart.

Esophageal cancer clusters in certain places. The highlands of Ethiopia fall in that cluster. The Arsi and Bale zones are especially affected [1]. The causes are part of daily life. People eat scalding porridge quickly before morning prayers. They drink coffee while it is still steaming. They chew khat in afternoon gatherings. They smoke cigarettes during long conversations. These are habits, not vices. They are cultural and social. But they cause terrible harm.

Nurses who care for esophageal cancer patients need clinical skills. They must know nutrition, pain management, respiratory care, and infection prevention. They also need something harder to teach. They must sit with despair without drowning in it. They must offer hope that is real, not empty. They must see the person, not just the diagnosis [2].

This case report tells the story of one patient. It covers the time between his diagnosis and his surgery. The body waits. The mind suffers. The nurse must hold both.

The Patient: A Life Interrupted

Who He Was

He was 45 years old. The disease had aged him. He was an Oromo farmer from a rural community. He worked the land all his life. He rose with the sun. He came home with dirt under his fingernails. He felt satisfaction in work completed.

He had two wives. This is not uncommon in his community. Between them he had five children. They depended on his labor and his presence. He had completed grade 8. He could read and write. He could understand the words "cancer" and "surgery" when doctors used them. His primary language was Oromifa. He also spoke Amharic, the language of the hospital.

He was a Muslim. He found comfort in prayer. He had participated in Irreechaa, the Oromo thanksgiving festival. In his hospital bed, he wanted to speak with his religious leader. He cared about his health. He sought medical help when ill. He had tried to stop harmful habits.

Two years before admission, he stopped smoking. He had smoked for seven years. A year and a half before admission, he stopped chewing khat. He had chewed it weekly for ten years. These were not small sacrifices in his community. They showed a man trying to live.

How It Began

The trouble started quietly. Six months before he came to us, solid food began to stick in his throat. At first he thought nothing of it. Maybe he ate too fast. Maybe the porridge was too thick.

But the sticking became resistance. Resistance became pain. Over months, his esophagus narrowed steadily. Solids became impossible. Then soft foods. Then liquids. By the time he reached our ward, even swallowing his own saliva caused severe pain. He had stopped trying.

He lost weight rapidly. We weighed him at 49 kilograms. His height was 1.73 meters. His body mass index was 16.37. This is severe malnutrition. His skin was dry. It was slow to return when pinched. His muscles were wasting. His hair was still black and evenly distributed. But it belonged to a body that was consuming itself.

In our charts we wrote "acute sick-looking." In human terms, he was a man watching his body fail him.

The Pain Beneath the Pain

The physical suffering was terrible. But it was only part of the story.

I sat with him to assess his health perception. He rated his overall health as 2 out of 3. Our scale called this "fair." "Poor" would have been more honest.

He was fully conscious. He knew person, place, and time. He could articulate his thoughts. He remembered recent and distant events. He could make decisions. His mind was clear. This made his psychological suffering worse. He understood exactly what was happening to him.

He was depressed. He felt hopeless. He had reason to feel this way. Some time before, he had watched a neighbor follow the same path. Progressive dysphagia. Weight loss. Diagnosis of esophageal cancer.

Decline. Death.

He carried that memory like a prophecy. He was certain his fate would match his neighbor's. When he spoke of his family, his voice changed. He feared he was leaving those who needed him most.

He coped in two ways. He prayed. He relied on his family. Now in the hospital, he relied on his brother-in-law. This man had left his own fields and obligations. He sat at the bedside. He bought medications when ordered. He provided human connection. No IV fluid can replace that.

The Road to Us

He did not come to us first. Like many rural patients, his journey had several stops. First was a health center. Antibiotics and painkillers gave temporary relief. Then a referral hospital. There, doctors suspected cancer. Finally our university hospital. Endoscopy would confirm what everyone feared.

He arrived on August 29, 2023. He came to the Surgery Ward. He brought his wasted body. He also brought a folder of investigations. And he brought fragile hope that something could still be done.

What We Found

Vital Signs

His vital signs showed stress but not crisis. Temperature was 36.9°C. Normal. Pulse was 62 beats per minute. Regular and strong. His heart still beat with quiet efficiency. Respiratory rate was 20. Regular. Blood pressure was 98/76 mmHg sitting, left arm. It was 93/73 on the right.

These numbers together told us something. His cardiovascular system was compensating. His body still fought to keep balance. It did this despite starvation and disease.

His oxygen saturation was 97%. Good on room air. We knew this would be tested if surgery came. Part of his esophagus would be removed. His respiratory system would need to recover from thoracic surgery.

Evidence of Starvation

The physical exam confirmed what his history suggested. He weighed 49 kilograms. His skin was dry. It was slow to rebound. His muscles were wasting. His hair was still black and evenly distributed. But his body was consuming itself.

His oral cavity was intact. Pink. Moist. This was a small mercy in a mouth that could no longer accept food. His nails were pink and convex. His tongue was healthy in color. These signs of preserved micronutrition gave us hope. With support, his body might still heal.

His abdomen told a quieter story. It was flat, not distended. No masses. No organomegaly. No fluid. Bowel sounds were normoactive. We heard gurgling nine times per minute. His digestive system still worked. It still waited for food that could not come.

The liver and spleen were palpable in normal positions. No shifting dullness. No fluid thrill. The cancer had not spread to these organs. Or if it had, we could not detect it with our hands.

The Pain

His pain was epigastric. It centered around the xiphoid process. It was dull and aching. Tramadol helped. We gave it as standing doses.

But pain is never just physical. His pain of swallowing had become so severe that he stopped trying. Not because he lacked thirst or hunger. Because the anticipation of pain had become its own torture.

I asked him to describe it. He used a word we hear too often in cancer wards: "burning." It started in his chest. It radiated outward. Saliva descending his esophagus felt like swallowing broken glass.

The behavioral signs were clear. Diaphoresis. Grimacing. Refusal to even attempt swallowing. These were not exaggerations. They were not manipulations. They were the body's honest testimony to a disease destroying the most basic human function.

The Mind

His cognitive assessment was normal. Glasgow Coma Scale 15. Oriented. Articulate. Memory intact. Decision-making capacity preserved.

In many ways, this clear mind was a curse. A patient who does not understand their prognosis may be spared certain fears. This man understood too well. He could read the concern in our eyes. He could understand delays in his surgery schedule. He could calculate the weight he lost each day.

His sleep was broken. He had trouble falling asleep. He had trouble staying asleep. When pain surged through the night, it stole what rest he might have found. He had no history of relaxation techniques. No meditation. No breathing exercises. He rested only when tramadol worked. Even then, rest was fragile.

The Social Fabric

He was father, provider, and leader in his family. His illness stripped him of all three. He was unemployed now. He could not farm. He depended on others for money to buy medications.

His social role had shrunk to a hospital bed and a small circle of visitors. Visitor flow was poor. Rural families cannot easily leave their fields and herds to sit in hospital wards. This isolation weighed on him.

But family support remained. His brother-in-law, Mr. Y, was his anchor. He understood that nursing care extends to those who love the patient. When I spoke with Mr. Y, he knew about the patient's condition. He was committed to his care. He also feared for his sister's husband and the family they shared.

The Diagnostic Journey

Confirmation

The diagnosis built step by step. The chest X-ray on admission showed asymmetrical thickening of the distal esophageal wall. The radiologist wrote: "likely esophageal cancer stage I." This phrase carried terrible news. But "stage I" also carried a whisper of hope.

The complete blood count was surprisingly normal. White blood cells 9.5. Hemoglobin 15.6. Hematocrit 49.1. Platelets 255. Red blood cells 4.8. These numbers suggested his body had not yet been consumed by systemic disease. His defenses still held.

Renal function tests were also reassuring. Creatinine 1.1. BUN 29.8. His kidneys still worked.

The ECG showed sinus bradycardia. His heart rate was slower than expected. This may reflect his malnourished state. It may simply be his baseline. It was not immediately concerning. But it reminded us that surgery would need careful cardiac monitoring.

Endoscopy three days after admission gave definitive visual evidence. A distal esophageal mass. Obstructing. Malignant in appearance. Biopsy would confirm what the eye suspected. But the clinical picture was already clear.

Staging

Staging changed everything. T1. Tumor confined to superficial layers of the esophagus. No invasion of deeper tissues. No lymph node involvement on imaging.

In esophageal cancer, many patients present at stage III or IV. They have metastatic disease. They have months to live. T1 is different. It means surgery can be curative. Five-year survival rates are favorable. This farmer, this father, might return to his fields and family.

I explained this to him. I sat beside his bed. I spoke slowly in Oromifa. I made sure he understood. I watched something shift in his face. The hopelessness did not vanish. It is never that simple. But something else joined it. Possibility. A future not yet written.

Barriers

The diagnosis was only the beginning. Barriers to timely care were formidable.

Our hospital had too few gastroenterologists for too many patients. The surgical schedule was limited to two days per week. This came from limited staffing and resources. But it felt cruelly inadequate when

cancer grew in a man's esophagus. Each day of waiting meant more starvation. More pain. More psychological erosion.

Cultural barriers also existed. The patient's primary language was Oromifa. He understood Amharic. But medical explanations have nuances. The difference between "treatable" and "curable." The meaning of "T1." These required careful, culturally sensitive communication. His beliefs about illness, shaped by community and religion, needed respect and integration into his care.

Invisible barriers also hurt. No psychologist for his depression. Insufficient time for regular staff to spend with each patient. No dedicated psychosocial support team. These were not failures of individual nurses. They were failures of a system that had not recognized mental health as part of cancer care.

Nursing Care

Nourishment Without Eating

The central challenge was nutritional support. His esophagus was completely blocked. He could not swallow. His BMI of 16.37 showed his body was already consuming its reserves. Before surgery, he needed strength. Strength to survive anesthesia. Strength to heal an anastomosis. Strength to fight infection.

Our approach was methodical. Every eight hours we rotated intravenous fluids. Normal Saline. Then Dextrose Normal Saline. Then Ringer's Lactate. Each bag was 1000 milliliters. It dripped steadily into a vein that became his lifeline.

With each fluid we added Vitamin B-Complex. Two ampules. This supported metabolic processes that starvation was disrupting. When Normal Saline was the carrier, we added 40% dextrose. This concentrated sugar gave energy his body craved but could not get from eating.

This was not nutrition as we normally understand it. No flavors. No textures. No satisfaction of hunger. Only biochemistry. Glucose. Electrolytes. Vitamins. Sustaining life through plastic tubing.

But it was enough. His fluid balance stabilized. His mucous membranes stayed moist. His skin turgor remained poor but did not worsen. In the most basic sense, he stayed alive.

Nursing care around these fluids was careful. We monitored intake and output with precision. We watched for fluid overload. Shortness of breath. Edema. Crackles in the lungs. We watched for dehydration. His dry skin and slow capillary refill already hinted at this risk.

We checked electrolytes. Prolonged IV therapy can disturb sodium, potassium, and chloride balance. We maintained strict asepsis for his IV line. Infection in a malnourished, immunocompromised patient could be catastrophic.

Pain Management

Pain management used both drugs and human connection. Tramadol as standing doses controlled his epigastric pain. After three days he no longer complained of the constant dull ache.

But cancer pain is never purely physical. Our nursing interventions went beyond the medication chart.

We used non-drug strategies. Positioning that reduced pressure on his abdomen. Conversation as distraction. A cool cloth on his forehead. We taught him about his pain plan. He did not need to suffer silently. Asking for medication was not weakness. It was wisdom.

We offered resources for coping with pain's psychological impacts. These resources were limited. We had no formal psychological services.

Most importantly, we believed him. When he said he hurt, we did not question if the pain was "really" that bad. We did not suggest exaggeration or drug-seeking. We accepted his pain as real. We responded with medication and with presence. This belief, this validation, is a form of healing no drug can provide.

Psychological Support

If nutritional support was the body of our care, psychological support was its soul.

This man was depressed. He was hopeless. He had watched a neighbor die of this disease. He saw his own future in that memory. When I first sat with him, he spoke of his fears with flat affect. He had already accepted the worst.

Our intervention began simply. We listened. I encouraged him to express his feelings about his health. He did so freely. With relief. Someone had finally given him permission to speak the unspeakable.

He spoke of his children. Of fields he might never plow again. Of God he prayed to for strength. He spoke of his neighbor's death. That memory had become a prison he could not escape.

Then came education. Not a lecture. A conversation. I explained his cancer stage, T1, and what it meant. I told him about success rates of esophagectomy for early-stage disease. I described the surgical plan. The intensive care unit where he would recover. The rehabilitation that would follow.

I did not promise cure. No ethical nurse makes promises they cannot keep. But I offered hope based on evidence. I told him his situation was not his neighbor's situation. Early-stage cancer was different. Surgery could work.

I watched this information settle into him. I watched him turn it over in his mind. I watched the slow shift from certainty of death to possibility of life. It was not dramatic. He did not smile or weep with joy. But he began to ask questions. About surgery. About recovery. About when he might return home.

These questions were hope. They assumed a future worth planning for.

I also involved his family. I spoke with his brother-in-law about presence. About reassurance. About helping the patient stay connected to life beyond the hospital. Family involvement is not just supportive. It is therapeutic. It provides social scaffolding that prevents psychological collapse.

Infection Prevention

This patient could not eat. His immune system was likely compromised by malnutrition. Infection prevention was critical.

We used standard infection control measures with extra vigilance. Hand hygiene before and after every contact. Aseptic technique for IV-line maintenance. Monitoring for early signs of infection. Fever. Tachycardia. Altered mental status. Localized redness or swelling.

We balanced rest with activity. Complete immobility would increase pneumonia and deep vein thrombosis risk. Too much activity would deplete his limited energy. We encouraged gentle movement as tolerated. Position changes to prevent pressure injuries. Deep breathing exercises to maintain respiratory function.

We monitored laboratory values. White blood cell count was our sentinel for infection. His WBC stayed normal throughout his preoperative stay. But we knew this could change fast. We stayed watchful.

Fluid Balance

Fluid management needed constant attention. He could not drink. He depended completely on IV fluids. But IV fluids cannot perfectly copy the body's natural regulation.

We monitored vital signs for clues. Tachycardia might mean low fluid volume. Hypertension might mean fluid overload. We examined his mucous membranes. We pinched his skin. We checked capillary refill. We tracked urine output. Adequate renal perfusion was both our goal and our marker of overall fluid status.

Laboratory values helped guide us. Normal creatinine and BUN were reassuring. But in a malnourished patient, these could look normal even with significant fluid imbalance. Clinical judgment remained our primary tool. Assessment of the whole patient.

The Waiting

Surgical Delay

Time was an enemy in this story. The patient had T1 esophageal cancer. This stage needs prompt surgery. But our hospital's surgical schedule was limited to two days per week.

The reason was not negligence. It was resource constraints. Too few surgeons. Too many patients. An operating theater that could not run continuously. But the effect on this patient was cruel. Day after day of waiting. Continued starvation. Psychological deterioration.

I watched him grow weaker. Despite our maintenance fluids, he stayed wasted. His body could not rebuild what cancer destroyed. Each day of delay meant more immunosuppression. More muscle wasting. More erosion of the reserves he needed to survive surgery.

In oncology we speak of "time to treatment" as a quality metric. For this patient, time was not a metric. It was an active enemy.

No Psychological Support

The waiting might have been bearable with psychological support. But our hospital had no psychologist in the surgical ward.

Regular staff nurses were competent and caring in clinical duties. But they showed poor concern for the patient's psychological state. They did not sit with him. They did not ask about his fears. They treated his body while his mind suffered alone.

I do not condemn them. They were overworked. Understaffed. Responsible for too many patients with too few resources. But the gap was real. And it was harmful.

A cancer patient needs more than physical care. He needs to know his terror is seen. His hopelessness is acknowledged. His humanity is recognized. Without this, physical care is incomplete.

As a nursing student, I tried to fill this gap. I sat with him. I reassured him. I explained and re-explained his prognosis, treatment plan, and future. But I was one person. I had limited time and authority. No individual nurse could fully compensate for missing systematic psychological care.

Systemic Gaps

Beyond surgical delay and missing psychology, other gaps appeared. No dedicated nutritionist to optimize his preoperative status beyond our basic IV support. No social worker for the financial strain on his family. They bought medications and supplies out of pocket. No palliative care team to consult. His early stage made curative intent appropriate. But the principle of early palliative care integration, even with curative treatment, was absent from our system.

These gaps are not unique to our hospital. They reflect broader challenges in resource-limited settings. Disease burden outstrips health system capacity. But common does not mean acceptable. Each gap is a point where care falls short of what patients need and deserve.

Outcomes

What Improved

After three days of intensive nursing care, improvements appeared. His epigastric pain, once constant, had decreased with standing tramadol doses. He no longer grimaced with every movement. His sleep,

still disturbed, was less broken. Pain no longer woke him hourly.

His fluid balance stayed stable. Vital signs were consistent. Mucous membranes moist. Skin turgor remained poor but did not worsen. Laboratory values stayed within normal limits. CBC. Renal function. Electrolytes. In the narrow physiological sense, we sustained him.

Most meaningfully, his psychological state improved. He expressed acceptance of his prognosis. Not resigned despair. Informed acceptance. He understood both risks and possibilities. He asked questions about recovery. About returning to his farm. About seeing his children again.

These questions showed hope rekindled.

His compliance with treatment was excellent. He accepted IV fluids without complaint. His brother-in-law bought medications and supplies promptly. Trust built through honest communication translated into cooperation with the care plan.

What Did Not

Improvements were partial and fragile. They were overshadowed by what stayed unchanged.

His nutritional status did not improve. Despite maintenance fluids, he remained wasted. His BMI stayed at 16.37. His body could not rebuild without enteral or parenteral nutrition more robust than we could provide. He was treading water. Not sinking. Not swimming. Just surviving.

His psychological improvement was real but shallow. Depression and hopelessness did not vanish. Our conversations and his growing understanding only held them back. Without ongoing psychological support, without surgery offering definitive hope, these feelings lurked beneath the surface. Ready to return.

The surgical delay continued. Each day brought no news of an operating room slot. The patient and family waited with special anxiety. They knew time was not neutral. Each passing day strengthened the enemy they were trying to defeat.

Adverse Events

No adverse events related to our nursing interventions occurred. No IV line infections. No fluid overload episodes. No allergic reactions to medications. The patient tolerated his care well. This showed our interventions were appropriate. It also showed his body still had residual resilience.

The unexpected challenge was the waiting duration itself. We had prepared for an acute preoperative period. Days. Perhaps a week. We had not prepared for weeks of sustained maintenance care. Watching a patient slowly deteriorate while waiting for the system to move. This prolonged preoperative state tested our interventions. Our patience. Our capacity to sustain hope despite delay.

Discussion

Strengths

This case shows several strengths in our nursing approach.

First, comprehensive assessment using Gordon's Functional Health Patterns gave a genuinely holistic understanding. We did not see him as "T1 esophageal cancer, male, 45 years." We saw a farmer. A father. A Muslim. A man who quit smoking and khat. A person with pneumonia history and fear of dying like his neighbor. This holistic view enabled nursing diagnoses addressing his whole being. Acute pain. Imbalanced nutrition. Fear. Anxiety. Risk for infection. Risk for fluid volume deficit.

Second, our interventions were evidence-based and appropriate for his stage and condition. Maintenance fluids with vitamin supplementation addressed immediate nutritional needs while preserving his gastrointestinal tract for future enteral feeding [5]. Pain management was effective and humane. Psychological support, though limited by systemic gaps, used therapeutic communication principles shown to enhance patient engagement and quality of life [13, 14].

Third, care occurred in a university hospital setting. Research shows this is associated with higher survival rates for esophageal cancer patients [10]. His T1 stage offered genuine hope for curative outcome with esophagectomy [7]. Our patient education about prognosis and treatment transformed his understanding from fatalism to informed hope. This transformation had measurable psychological benefits.

Limitations

The limitations were stark and systemic.

Surgical delay, limited to two days per week due to staffing constraints, represents critical healthcare delivery failure. In cancer care, time is tissue. Each day of delay allows tumor growth, nutritional deterioration, and psychological decline [11]. This is not nursing failure. It is system failure. It demands advocacy for increased surgical capacity, more trained gastroenterologists, and operating theaters that can run with the urgency cancer requires.

The absence of dedicated psychological support was equally damaging. Esophageal cancer patients experience high rates of depression, anxiety, and stress [9]. These are not optional add-ons to physical care. They are integral to patient outcomes. They affect treatment compliance, quality of life, and potentially survival. Regular staff nurses showed poor concern for his psychological state. This reflects both individual attitudes and systemic failures in training, staffing, and prioritization of mental health in oncology settings.

Nutritional support, adequate for short-term maintenance, was insufficient for preoperative optimization. Patients with esophageal cancer and BMI 16.37 need more aggressive intervention. Enteral feeding via

nasogastric or jejunostomy tube. Or parenteral nutrition if enteral access is impossible [8]. Our maintenance fluids prevented immediate crisis. But they did not rebuild the reserves he needed to survive surgery and recover.

What This Case Teaches

Lessons from this case extend beyond one patient. They reach the systems and philosophies shaping cancer care in resource-limited settings.

Holistic nursing assessment is not optional. It is essential. A patient with esophageal cancer is not merely an esophagus with a tumor. He is a person with family, faith, history, and future. Nursing care that addresses only the physical dimension while ignoring psychological, social, and spiritual needs is incomplete.

Nutritional support must be aggressive and creative. When a patient cannot eat, the healthcare team must find other ways to nourish them. Maintenance fluids are a bridge, not a destination. For patients awaiting esophagectomy, preoperative nutritional optimization may determine postoperative survival.

Psychological care is cancer care. Depression and hopelessness are not side effects to manage after the "real" treatment. They are central to patient experience. They directly impact outcomes. Healthcare systems must invest in psychological services for oncology patients. Nursing education must prioritize emotional intelligence and communication skills.

Systemic advocacy is a nursing responsibility. We cannot accept surgical delays, staffing shortages, and resource gaps as unchangeable facts. Nurses must advocate within their institutions, to policymakers, and in public forums. They must fight for resources and systems that enable quality cancer care.

Hope must be honest. The patient's transformation from hopelessness to informed hope came not from false promises but from accurate information delivered with compassion. T1 esophageal cancer is genuinely treatable. Surgery genuinely offers cure. These truths, communicated clearly, became the foundation for rebuilding his psychological resilience.

Finally, this case shows both the profound impact and painful limitations of nursing care in resource-constrained settings. When a patient cannot eat, the nurse feeds them through IV lines. When a patient loses hope, the nurse offers facts that help them hope again. But nurses cannot operate. They cannot create psychologists who do not exist. They cannot make a two-day surgical schedule serve a ward full of cancer patients. Holistic nursing care is not a luxury. It is a necessity. Healthcare systems must be strengthened to support the nurses who stand at the frontline of cancer care.

The Patient's Voice

Near the end of my time with him, I asked if he would share his experience for others who might read this report. He agreed. His words, translated from Oromifa, carry authenticity no clinical description can

match.

"I was very afraid before," he said. He sat up slightly in his bed. The IV line still ran into his arm. "When I could not eat, I thought it was the end. I remembered my neighbor, how he suffered, how he died. I thought God had given me the same punishment."

He paused. He looked at his hands. They had grown thin and pale in the weeks of illness.

"But then you explained to me. You told me about the stage, about the surgery, about how it can be removed. I did not know these things before. In my village, when someone gets this sickness, we think only of death. Now I understand that my sickness is different. It is early. The doctors can cut it out."

He looked up. For the first time since I had known him, something like light appeared in his eyes.

"This gives me hope. Not big hope. Not like I am already healed. But hope that I might see my children again. That I might work my land again. That I might live."

He also spoke of the waiting. "The waiting is hard. Each day I wake up and ask, 'Is it today? Will they operate today?' And each day the answer is no. This waiting makes me tired. It makes me wonder if the sickness is growing while I wait."

And of his family: "My brother-in-law has been here every day. He buys the medicines. He sits with me. My wives cannot come. They must care for the children, for the farm. But they call when they can. I worry about them. About what will happen to them if I do not return."

Finally, he spoke of his faith: "I pray. Every day, I pray to Allah. I ask for strength. I ask for healing. The nurse told me that prayer is good, that it can help. So I pray, and I also trust the doctors. Both together, I think, are better than one alone."

I asked what he would want other patients to know. He answered simply: "Do not wait. When you cannot swallow, go to the hospital quickly. The early sickness is better than the late sickness. And trust the nurses. They know things. They can help you understand."

Declarations

Informed Consent

Written informed consent was obtained from the patient for publication of this case report and disclosure of his clinical information. He was informed that his identity would be fully anonymized. No names, specific locations, or identifiable dates would be published. He could withdraw consent at any time. All patient identifiers have been removed or altered to protect confidentiality. This follows the CARE Guidelines and institutional ethical standards. The patient reviewed the content and approved its publication.

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Ethics Approval:

Ethical approval for this case report was obtained from the Institutional Review Board (IRB) of the Medical Ethical and Research Ethics Evaluation Committee, College of Medicine and Health Sciences, Wachemo University, Hossana, Ethiopia (Reference No. CMHS/IRB/2941/2026). The study was conducted in accordance with the ethical principles of the Declaration of Helsinki and the research ethics guidelines of Wachemo University. Written informed consent for participation and publication of the case details and accompanying images was obtained from the patient prior to manuscript submission.

Consent for Publication

Written informed consent was obtained from the patient for publication of this case report and any accompanying information. A copy of the written consent is available for review by the Editor of this journal upon request from the author.

Availability of Data and Materials: The datasets during history taking and physical examination during the current case report are available from the corresponding author on reasonable request.

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Authors' Contributions

Biruk A. Getiso conceived the case report, conducted the nursing assessment and interventions, analyzed the data, and wrote the manuscript. The author read and approved the final manuscript.

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